

		FOR OHF USE					

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**2004**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2004)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0035246</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Henderson County Retirement Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>604 Oakwood Dr</u> <u>Stronghurst</u> <u>61480</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Henderson</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
<b>Telephone Number:</b> <u>309-924-1123</u> <b>Fax #</b> <u>309-924-1926</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>James G. Hull</u> <u>Vice President</u> (Firm Name & Address) <u>WDM Computer Svcs</u> <u>1900 Harrison, Quincy, IL 62301</u> (Telephone) <u>217-228-1950</u> <b>Fax #</b> <u>217-222-6053</u>	
<b>IDPA ID Number:</b> <u>363378161101</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone # (217) 782-1630</b>	
<b>Date of Initial License for Current Owners:</b> <u>06/28/89</u>			
<b>Type of Ownership:</b>			
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
<b>IRS Exemption Code</b> <u>501 c 3</u>			
<input type="checkbox"/> <b>PROPRIETARY</b>			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<b>GOVERNMENTAL</b>			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>James G. Hull</u> <b>Telephone Number:</b> <u>217-228-1950</u>			

## STATE OF ILLINOIS

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Facility Name & ID Number Henderson County Retirement Center# 0035246 Report Period Beginning: 01/01/04 Ending: 12/31/04

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>70</u>	Skilled (SNF)	<u>70</u>	<u>25,620</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>70</u>	TOTALS	<u>70</u>	<u>25,620</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>10,905</u>	<u>7,998</u>		<u>18,903</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,905</u>	<u>7,998</u>		<u>18,903</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 73.78%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/28/89

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 05/16/89 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

\* All facilities other than governmental must report on the accrual basis.

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Facility Name &amp; ID Number Henderson County Retirement Center # 0035246 Report Period Beginning: 01/01/04 Ending: 12/31/04

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	113,235	11,854	4,245	129,334		129,334	(629)	128,705		1
2	Food Purchase		109,670		109,670		109,670		109,670		2
3	Housekeeping	71,160	4,672		75,832		75,832		75,832		3
4	Laundry	31,961	5,650	29,512	67,123		67,123		67,123		4
5	Heat and Other Utilities			52,927	52,927		52,927		52,927		5
6	Maintenance		2,123	66,107	68,230		68,230		68,230		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	216,356	133,969	152,791	503,116		503,116	(629)	502,487		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,380	13,380		13,380		13,380		9
10	Nursing and Medical Records	621,663	68,612	1,800	692,075		692,075		692,075		10
10a	Therapy	21,601	190	320	22,111		22,111		22,111		10a
11	Activities	47,473	5,497	1,770	54,740		54,740		54,740		11
12	Social Services	33,133	1,525	1,770	36,428		36,428		36,428		12
13	Nurse Aide Training	776	145	699	1,620		1,620		1,620		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	724,646	75,969	19,739	820,354		820,354		820,354		16
	<b>C. General Administration</b>										
17	Administrative	43,166			43,166		43,166		43,166		17
18	Directors Fees										18
19	Professional Services			20,171	20,171		20,171		20,171		19
20	Dues, Fees, Subscriptions & Promotions			13,034	13,034		13,034	(7,496)	5,538		20
21	Clerical & General Office Expenses	42,013	7,724	11,581	61,318		61,318		61,318		21
22	Employee Benefits & Payroll Taxes			191,511	191,511		191,511		191,511		22
23	Inservice Training & Education			853	853	549	1,402		1,402		23
24	Travel and Seminar			2,181	2,181	(549)	1,632		1,632		24
25	Other Admin. Staff Transportation		2,144		2,144		2,144		2,144		25
26	Insurance-Prop.Liab.Malpractice			69,481	69,481		69,481		69,481		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	85,179	9,868	308,812	403,859		403,859	(7,496)	396,363		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,026,181	219,806	481,342	1,727,329		1,727,329	(8,125)	1,719,204		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name &amp; ID Number Henderson County Retirement Center

#0035246

Report Period Beginning:

01/01/04

Ending:

12/31/04

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			115,338	115,338		115,338	(12,084)	103,254			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			59,138	59,138		59,138	(8,498)	50,640			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,693	4,693		4,693		4,693			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			179,169	179,169		179,169	(20,582)	158,587			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		141		141		141		141			39
40	Barber and Beauty Shops			10,772	10,772		10,772		10,772			40
41	Coffee and Gift Shops		3,790		3,790		3,790		3,790			41
42	Provider Participation Fee			38,430	38,430		38,430		38,430			42
43	Other (specify):*			599	599		599	(599)				43
44	<b>TOTAL Special Cost Centers</b>		3,931	49,801	53,732		53,732	(599)	53,133			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,026,181	223,737	710,312	1,960,230		1,960,230	(29,306)	1,930,924			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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Facility Name &amp; ID Number Henderson County Retirement Center

# 0035246

Report Period Beginning: 01/01/04

Ending: 12/31/04

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(629)	1		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(88)	30		9
10 Interest and Other Investment Income	(8,498)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(7,496)	20		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(12,595)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (29,306)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (29,306)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Henderson County Retirement Center

ID# 0035246

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Bank Fees	\$ (599)	43	1
2	Lease Butout Deprec	(11,996)	30	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(12,595)		49

## Summary A

12/31/04

12/31/04

[illegible]





**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Henderson County Retirement Center # 0035246 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Henderson County Retirement Center # 0035246 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Mortgage		X	Mortgage	\$8,749.78	04/01/93	\$ 2,000,000	\$ 959,387	07/01/18	5.8720	\$ 59,138	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$8,749.78		\$ 2,000,000	\$ 959,387			\$ 59,138	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,000,000	\$ 959,387			\$ 59,138	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Henderson County Retirement Center**# **0035246** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2003 report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1999		8	
	2000		9	
	2001		10	
	2002		11	
	2003		12	
<b>FOR OHF USE ONLY</b>				
	13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    Henderson County Retirement Center    COUNTY    Henderson

FACILITY IDPH LICENSE NUMBER    0035246

CONTACT PERSON REGARDING THIS REPORT    \_\_\_\_\_

TELEPHONE (    )    FAX #: (    )

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	<b>\$ _____</b>	<b>\$ _____</b>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    \_\_\_\_\_ YES    \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

A. Square Feet:

18,636

B. General Construction Type:

Exterior

Brick

Frame

Wood-Steel

Number of Stories

1

C. Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Care Related	217,600	1988	\$ 15,000	1
2					2
3	TOTALS	217,600		\$ 15,000	3

**XL OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	60	1989	1988	\$ 1,260,000	\$ 42,031	30	\$ 42,000	\$ (31)	\$ 654,048
5	6	2000	2000	530,989	13,301	40	13,275	(26)	57,913
6									
7									
8									
<b>Improvement Type**</b>									
9	PARKING LOT/LANDSCAPING	1989		25,102	1,258	20	1,255	(3)	19,307
10	LANDSCAPING	1990		937	47	20	47		667
11	LAND IMPROVEMENT	1995		1,839	92	20	92		905
12	BRICK SIGN	1996		12,915	620	12	646	26	5,678
13	LAND IMPROVEMENT	1992		2,003	101	20	100	(1)	1,214
14	LIGHTNING RODS	1998		3,600	240	15	240		1,580
15	NEW SOFFITS	1998		26,138	1,752	15	1,743	(9)	11,390
16	PHONE SYSTEM	1998		6,738	449	15	449		2,882
17	SIDE WALKS	1998		4,500	226	20	225	(1)	1,393
18	ALARM SYSTEM	1998		8,266	834	10	827	(7)	5,140
19	LAUNDRY/GARAGE BLDG	1999		50,330	3,374	15	3,355	(19)	17,995
20	STORAGE BLDG	1999		8,911	597	15	594	(3)	3,186
21	NEW ROOF	1999		16,311	1,093	15	1,087	(6)	5,558
22	LANDSCAPING	2000		1,706	85	20	85		356
23	FURNICE	2001		2,848	285	10	285		1,116
24	NEW EXIT	2001		1,645	110	15	110		414
25	LANDSCAPING	2002		954	95	10	95		254
26	GARAGE/STORAGE BUILDING	2002		12,800	858	15	853	(5)	2,073
27	ROOFING/SHINGLES	2003		17,838	1,192	15	1,189	(3)	1,750
28									
29									
30									
31									
32									
33									
34									
35									
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,996,370	\$ 68,640		\$ 68,552	\$ (88)	\$ 794,819	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 534,837	\$ 29,157	\$ 29,157	\$	10	\$ 443,580	71
72	Current Year Purchases	12,666	545	545		10	545	72
73	Fully Depreciated Assets	64,217				10	64,217	73
74								74
75	TOTALS	\$ 611,720	\$ 29,702	\$ 29,702	\$		\$ 508,342	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Related	Dodge Van	1998	\$ 8,000	\$	\$		5	\$ 8,000	76
77	Care Related	1997 Ford Eldorado	2002	25,000	5,000	5,000		5	10,417	77
78										78
79										79
80	TOTALS			\$ 33,000	\$ 5,000	\$ 5,000	\$		\$ 18,417	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,656,090	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 103,342	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 103,254	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (88)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,321,578	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ 4,693

Description: Oxygen Conc., Nebulizer, & Copier

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ \_\_\_\_\_

13. /2006 \$ \_\_\_\_\_

14. /2007 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input checked="" type="checkbox"/>
		COMMUNITY COLLEGE <input checked="" type="checkbox"/>	HOURS PER AIDE <u>40</u>
		HOURS PER AIDE <u>80</u>	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	699	\$	699
2	Books and Supplies		45		45
3	Classroom Wages (a)		526		526
4	Clinical Wages (b)		250		250
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		100		100
9	TOTALS	\$	1,620	\$	1,620
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,620		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language										
2	Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 133,427	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	241,210		3
4	Supply Inventory (priced at FIFO )	11,525		4
5	Short-Term Investments	218,797		5
6	Prepaid Insurance	29,344		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 634,303	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,500		13
14	Buildings, at Historical Cost	2,369,112		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	648,704		16
17	Accumulated Depreciation (book methods)	(1,462,375)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,577,941	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,212,244	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 23,318	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,577		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,695		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Other Payroll Liabilities</u>	4,133		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 130,723	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	959,387		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 959,387	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,090,110	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,122,134	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,212,244	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 1,183,975</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 1,183,975</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(61,841)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (61,841)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 1,122,134</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 1,857,737	1
2	Discounts and Allowances for all Levels	(16,736)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,841,001	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	1,115	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,115	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	4,621	12
13	Barber and Beauty Care	10,100	13
14	Non-Patient Meals	629	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	231	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 15,581	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	11,877	24
25	Interest and Other Investment Income***	8,498	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 20,375	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Transportation	962	28
28a	See List Attached	19,355	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 20,317	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,898,389	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	503,116	31
32	Health Care	820,354	32
33	General Administration	403,859	33
	<b>B. Capital Expense</b>		
34	Ownership	179,169	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	15,302	35
36	Provider Participation Fee	38,430	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,960,230	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(61,841)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (61,841)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name &amp; ID Number Henderson County Retirement Center

# 0035246

Report Period Beginning: 01/01/04

Ending:

12/31/04

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,901	2,433	\$ 46,250	\$ 19.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,403	2,651	41,590	15.69	3
4	Licensed Practical Nurses	14,083	15,833	219,387	13.86	4
5	Nurse Aides & Orderlies	33,384	36,315	275,651	7.59	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,453	1,823	21,601	11.85	8
9	Activity Director	1,780	2,088	19,942	9.55	9
10	Activity Assistants	3,981	4,217	27,531	6.53	10
11	Social Service Workers	3,166	3,706	33,133	8.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,788	2,075	18,377	8.86	14
15	Cook Helpers/Assistants	5,626	6,139	40,005	6.52	15
16	Dishwashers	8,203	8,914	54,853	6.15	16
17	Maintenance Workers					17
18	Housekeepers	10,309	11,208	71,160	6.35	18
19	Laundry	3,385	3,828	31,961	8.35	19
20	Administrator	1,848	2,178	43,166	19.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,479	4,258	42,013	9.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coord.	1,740	2,088	38,786	18.58	32
33	Other(specify)			775		33
34	TOTAL (lines 1 - 33)	98,529	109,754	\$ 1,026,181 *	\$ 9.35	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	130	\$ 4,245	1-3	35
36	Medical Director	Contract	13,380	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Contract	1,800	10-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3 Sessions	320	10a-3	43
44	Activity Consultant	Contract	1,770	11-3	44
45	Social Service Consultant	Contract	1,770	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	130	\$ 23,285		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name &amp; ID Number Henderson County Retirement Center

# 0035246

Report Period Beginning: 01/01/04

**Ending:** 12/31/04

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Richard Clifton	Administrator	0	\$ 43,166	Workers' Compensation Insurance		\$ 62,838	IDPH License Fee		\$		
				Unemployment Compensation Insurance		3,383	Advertising: Employee Recruitment		768		
				FICA Taxes		76,118	Health Care Worker Background Check		612		
				Employee Health Insurance		49,172	(Indicate # of checks performed 46 )				
				Employee Meals			Advert/Promotions		7,496		
				Illinois Municipal Retirement Fund (IMRF)*			Subscriptions		458		
							LSN Membership		3,245		
							Naeir Dues		40		
							LTCNA/AANAC Dues		170		
							License Fees		245		
							Less: Public Relations Expense		(3,469)		
							Non-allowable advertising		(4,027)		
							Yellow page advertising	(			
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)			\$ 43,166				TOTAL (agree to Sch. V, line 20, col. 8)	\$	5,538		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)							
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
N/A			\$ 0	Description	Line #	Amount	Description		Amount		
				N/A		\$ 0	Out-of-State Travel		\$		
							In-State Travel				
							Seminar Expense		1,632		
							Entertainment Expense	(			
TOTAL (agree to Schedule V, line 17, col. 3)							(agree to Sch. V, line 24, col. 8)				
(Attach a copy of any management service agreement)				TOTAL		\$	TOTAL		\$ 1,632		
C. Professional Services											
Vendor/Payee	Type		Amount								
WDM Computer Services, Inc.	Data Processing		\$ 17,361								
Stoerzbach Morrison, Robertson	Legal		535								
Fort & Neff	Legal		25								
Doran Insurance	Benefits Administration		250								
Universal RE	Insurance Inspection Fee		2,000								

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Servies Network 3245
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 8 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,522 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 38,430  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 629
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 90  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

Henderson County Retirement Center, Inc.

#0035246

01/01/04 to 12/31/04

Board Members

Diana Doran, Pres 2005  
Box 417  
Carman, IL 61425

Gary Martin, 2007  
Box 245  
Oquawka, IL 61469

Sally Fisher 2006  
RR 1  
Lomax, IL 61454

Tom Edmonds, 2006  
RR 1, Box 129  
Lomax, IL 61454

John Allaman, Treas. 2007  
RR 1  
Kirkwood, IL 61447

Tony Griepentrog, 2006  
Box 111  
Stronghurst, IL 61480

Nancy Stevenson, Sec. 2005  
RR 1  
Gladstone, IL 61437

Susan Towns, 2005  
P.O. Box 447  
Stronghurst, IL 61480

Ralph Tatge, 2007 (Vice Pres.)  
Box 535  
Stronghurst, IL 61480

Honorary Board Members

Laura Kent Donahue  
Zach Stamp

Henderson County Retirement Center, Inc.

#0035246

01/01/04 to 12/31/04

Reclassifications

1. Reclassify \$549.00 from line 24 to line 23, due to an on-line training course being coded to seminars.

Henderson County Retirement Center, Inc.

#0035246

01/01/04 to 12/31/04

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	\$663.46
REPAIRS & MAINT BUILDING	\$5,758.60
REPAIRS & MAINT EQUIP	\$12,328.54
REPAIRS & MAINT GROUNDS	\$655.11
REPAIRS & MAINT LAUNDRY	\$1,053.12
REPAIRS & MAINT HSK	\$32.94
REPAIRS & MAINT ALARM	\$618.49
REPAIRS & MAINT GEN/ADM	\$1,287.75
OUTSIDE SERVICES	\$36,988.66
REFUSE	\$6,411.58
Rent	\$309.00
EXTERMITATOR	\$0.00
TOTAL	<u>\$66,107.25</u>

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	\$6,523.05
Board Minutes	\$35.00
Software Support	\$4,724.00
Internet Service	\$299.40
TOTAL	<u>\$11,581.45</u>

Schedule V. Line 25, Column 2

Auto Exp. & Service	\$638.37
Auto Gas & Oil	\$849.13
Business Mileage Expense	<u>\$656.68</u>
	\$2,144.18

Schedule V. Line 43, Column3

Misc. Exp.	\$599.40
Charitable Contributions	<u>\$0.00</u>
	\$599.40

Schedule XX. Question 12

All salaries are allocated on the basis of actual time worked in each department.

Schedule XVII, Line 28a, Column 1

Diaper Income	\$17,370.00
Admissions	\$630.00
Gain on Sale of Asset	\$0.00
Personal Purchases	-\$143.80
Miscellaneous	\$973.00
Dues	\$525.00
Rounding	\$1.00
	<u>\$19,355.20</u>